

ACORD		CERTIFICATE OF LIABILITY INSURANCE																			
		DATE (MM/DD/YYYY)																			
PRODUCER NAME & ADDRESS OF INSURANCE AGENCY ISSUING CERTIFICATE OF INSURANCE		THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.																			
INSURED NAME & ADDRESS OF INSURED		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: left;">INSURERS AFFORDING COVERAGE</th> <th style="text-align: left;">NAIC #</th> </tr> <tr> <td style="width: 50%;">INSURER A:</td> <td colspan="2"></td> </tr> <tr> <td>INSURER B:</td> <td colspan="2">MUST BE LICENSED IN NEW YORK STATE</td> </tr> <tr> <td>INSURER C:</td> <td colspan="2"></td> </tr> <tr> <td>INSURER D:</td> <td colspan="2"></td> </tr> <tr> <td>INSURER E:</td> <td colspan="2"></td> </tr> </table>		INSURERS AFFORDING COVERAGE		NAIC #	INSURER A:			INSURER B:	MUST BE LICENSED IN NEW YORK STATE		INSURER C:			INSURER D:			INSURER E:		
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COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
A	<input checked="" type="checkbox"/>	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR <input type="checkbox"/> _____ GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC	POLICY #	MM/DD/YY	MM/DD/YY	EACH OCCURENCE \$1,000,000. DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	<input type="checkbox"/>	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS <input type="checkbox"/> _____				COMBINED SINGLE LIMIT (Each Occurrence) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)
	<input type="checkbox"/>	GARAGE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> _____				AUTO ONLY - EA ACCIDENT OTHER THAN EA ACC AUTO ONLY: AGG \$
	<input type="checkbox"/>	EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION \$				EACH OCCURENCE \$ AGGREGATE \$ \$ \$ \$
	<input type="checkbox"/>	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	CANNOT BE FILED ON ACCORD FORM	CANNOT BE FILED ON ACCORD FORM	CANNOT BE FILED ON ACCORD FORM	<input type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
	<input type="checkbox"/>	OTHER				

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

(Must Read): CERTIFICATE HOLDER IS ADDITIONAL INSURED.

CERTIFICATE HOLDER

CITY OF YONKERS
 87 NEPPERHAN AVENUE
 YONKERS, NEW YORK 10701

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE INSURER AFFORDING COVERAGE WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (Use street address only) Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)	1b. Business Telephone Number of Insured 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) City of Yonkers 87 Nepperhan Ave Yonkers, NY 10701	3a. Name of Insurance Carrier 3b. Policy Number of entity listed in box "1a" 3c. Policy effective period _____ to _____ 3d. The Proprietor, Partners or Executive Officers are included. (Only check box if all partners/officers included) all excluded or certain partners/officers excluded.

This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. **(To use this form, New York (NY) must be listed under Item 3A on the INFORMATION PAGE of the workers' compensation insurance policy).** The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holder in box "2".

The Insurance Carrier will also notify the above certificate holder within 10 days IF a policy is canceled due to nonpayment of premiums or within 30 days IF there are reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (These notices may be sent by regular mail.) Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.

Please Note: Upon the cancellation of the workers' compensation policy indicated on this form, if the business continues to be named on a permit, license or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of Workers' Compensation Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law.

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has the coverage as depicted on this form.

Approved by: _____
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____
(Signature) (Date)

Title: _____

Telephone Number of authorized representative or licensed agent of insurance carrier: _____

Please Note: Only insurance carriers and their licensed agents are authorized to issue Form C-105.2. Insurance brokers are NOT authorized to issue it.



New York State Insurance Fund

Workers' Compensation & Disability Benefits Specialists Since 1914

199 CHURCH STREET, NEW YORK, N.Y. 10007-1100
Phone: (888) 997-3863

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

EXAMPLE ONLY

***** 112144392
A SUB NAMED BOB
123 MAIN STREET
YOUR TOWN NY 12345

POLICYHOLDER
A SUB NAMED BOB
123 MAIN STREET
YOUR TOWN NY 12345

CERTIFICATE HOLDER
CITY OF YONKERS
87 NEPPERHAN AVE
YONKERS, NY 10701

POLICY NUMBER	CERTIFICATE NUMBER	PERIOD COVERED BY THIS CERTIFICATE	DATE
G 1319 656-3	281982	06/29/2010 TO 06/29/2011	10/12/2010

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 1319 656-3 UNTIL 06/29/2011, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW.

IF SAID POLICY IS CANCELLED, OR CHANGED PRIOR TO 06/29/2011 IN SUCH MANNER AS TO AFFECT THIS CERTIFICATE, 10 DAYS WRITTEN NOTICE OF SUCH CANCELLATION WILL BE GIVEN TO THE CERTIFICATE HOLDER ABOVE. NOTICE BY REGULAR MAIL SO ADDRESSED SHALL BE SUFFICIENT COMPLIANCE WITH THIS PROVISION. THE NEW YORK STATE INSURANCE FUND DOES NOT ASSUME ANY LIABILITY IN THE EVENT OF FAILURE TO GIVE SUCH NOTICE.

THIS CERTIFICATE DOES NOT APPLY TO THOSE JOB SITES WHICH ARE COVERED BY OTHER INSURANCE AND ARE SPECIFICALLY EXCLUDED BY ENDORSEMENT.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NOT A VALID CERTIFICATE

NEW YORK STATE INSURANCE FUND

John Manetti

DIRECTOR, INSURANCE FUND UNDERWRITING

This certificate can be validated on our web site at <https://www.nysif.com/cert/certval.asp> or by calling (888) 875-5790
VALIDATION NUMBER: 788813962



Mayor Mike Spano

CITY OF YONKERS

Vincent Pici, P.E., M.P.A.
Commissioner

DEPARTMENT OF HOUSING AND BUILDINGS

87 Nepperhan Avenue, 5th Floor
Yonkers, NY 10701

Building Tel 914 377 6500

Fax 914 377 6521

Housing Tel 914 377 6536

Fax 914 377 6496

**HOMEOWNER'S, ESTATE *AND/OR* CONTRACTOR'S HOLD HARMLESS
INDEMNIFICATION AGREEMENT WITH THE CITY OF YONKERS**

(Name of Homeowner, Company or Contractor)

In consideration of the City of Yonkers issuing permits to perform work in the City, herewith agrees, that, at its expense, it will protect, defend, indemnify, and hold the City of Yonkers and its servants and agents harmless from all losses sustained, claims, liens, or demands made, cause of action, suits filed, judgments awarded or penalties, interest, court costs or attorneys' fees incurred, arising from or in connection with the work.

Job Site Address: _____

Block: _____; Lot: _____

Application No.: _____

Dated: _____

Signature: _____

Print Name: _____

Sworn before me this ____ day of _____, 20__

Commissioner of Deeds or Notary Public

Please return ORIGINAL Hold Harmless form to the City of Yonkers, Department of Housing and Buildings, 87 Nepperhan Avenue, 5th floor, Yonkers, NY 10701

ORIGINAL DOCUMENT, ORIGINAL SIGNATURE IS REQUIRED

Affidavit of Exemption to Show Specific Proof of Workers' Compensation Insurance Coverage for a 1, 2, 3 or 4 Family, Owner-occupied Residence

Under penalty of perjury, I certify that I am the owner of the 1, 2, 3 or 4 family, **owner-occupied** residence (including condominiums) listed on the building permit that I am applying for, and I am not required to show specific proof of workers' compensation insurance coverage for such residence because (please check the appropriate box):

- ☐ I am performing all the work for which the building permit was issued.
- ☐ I am not hiring, paying or compensating in any way, the individual(s) that is(are) performing all the work for which the building permit was issued or helping me perform such work.
- ☐ I have a homeowners insurance policy that is currently in effect and covers the property listed on the attached building permit AND am hiring or paying individuals a total of less than 40 hours per week (aggregate hours for all paid individuals on the jobsite) for which the building permit was issued.

I also agree to either:

- ◆ acquire appropriate workers' compensation coverage and provide appropriate proof of that coverage on forms approved by the Chair of the NYS Workers' Compensation Board to the government entity issuing the building permit if I need to hire or pay individuals a total of 40 hours or more per week (aggregate hours for all paid individuals on the jobsite) for work indicated on the building permit; OR
- ◆ have the general contractor, performing the work on the 1, 2, 3 or 4 family, **owner-occupied** residence (including condominiums) listed on the building permit that I am applying for, provide appropriate proof of workers' compensation coverage or proof of exemption from that coverage on forms approved by the Chair of the NYS Workers' Compensation Board to the government entity issuing the building permit if the project takes a total of 40 hours or more per week (aggregate hours for all paid individuals on the jobsite) for work indicated on the building permit.

(Signature of Homeowner)

(Date Signed)

(Homeowner's Name Printed)

Home Telephone Number _ _ _ _ _

Property Address that requires the building permit:

BP-1 (3/99)

<p><i>Sworn to before me this _____ day of</i></p> <p>_____, _____.</p> <p>_____ <i>(County Clerk or Notary Public)</i></p>

Effective December 20, 2011

New York State Workers Compensation
CE-200 EXEMPTION FORM

is available at www.wcb.ny.gov

FOR AN ON-LINE APPLICATION:

CE-200 (12/08) is an on-line application that allows an immediate print of the exemption form.

- Click on **On-Line Services** – on the right side of the screen.
- Then click on **Request for WC/DB Exemption** and follow the directions.

OR

FOR AN APPLICATION BY MAIL:

CE-200 (2/09) is an application which must be printed and mailed/faxed to Albany. The exemption certificate is then mailed to the applicant.

- Click on **Forms** – at the top center of the page.
- Click on **List of ALL Common Workers Compensation Board Forms**.
The forms are in ALPHABETICAL ORDER.
Scroll down to **CE-200 (2/09)** – which is half way down the page.



**Certificate of Attestation of Exemption
From New York State Workers' Compensation
and/or Disability Benefits Insurance Coverage**

****This form cannot be used to waive the workers' compensation rights or obligations of any party.****

The applicant may use this Certificate of Attestation of Exemption **ONLY** to show a government entity that New York State specific workers' compensation and/or disability benefits insurance is not required. The applicant may **NOT** use this form to show another business or that business's insurance carrier that such insurance is not required.

Please provide this form to the government entity from which you are requesting a permit, license or contract. This Certificate will not be accepted by government officials one year after the date printed on the form.

In the Application of (Legal Entity Name and Address):	Business Applying For: Building Permit From: CITY OF YONKERS The location of where work will be performed is Estimated dates necessary to complete work associated with the building permit are from The estimated dollar amount of project is \$0 - \$10,000
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Workers' Compensation Exemption Statement:




The above named business is certifying that it is **NOT REQUIRED TO OBTAIN NEW YORK STATE SPECIFIC WORKERS' COMPENSATION INSURANCE COVERAGE** for the following reason:

The business is a one person owned corporation, with that individual owning all of the stock and holding all offices of the corporation. Other than the corporate owner, there are no employees, day labor, leased employees, borrowed employees, part-time employees, other stockholders, unpaid volunteers (including family members) or subcontractors.

Disability Benefits Exemption Statement:

The applicant is **NOT** applying for a disability benefits exemption and will show a separate certificate of NYS statutory disability benefits insurance coverage.

I, _____, am the President with the above-named legal entity. I affirm that due to my position with the above-named business I have the knowledge, information and authority to make this Certificate of Attestation of Exemption. I hereby affirm that the statements made herein are true, that I have not made any materially false statements and I make this Certificate of Attestation of Exemption under the penalties of perjury. I further affirm that I understand that any false statement, representation or concealment will subject me to felony criminal prosecution, including jail and civil liability in accordance with the Workers' Compensation Law and all other New York State laws. By submitting this Certificate of Attestation of Exemption to the government entity listed above I also hereby affirm that if circumstances change so that workers' compensation insurance and/or disability benefits coverage is required, the above-named legal entity will immediately acquire appropriate New York State specific workers' compensation insurance and/or disability benefits coverage and also immediately furnish proof of that coverage on forms approved by the Chair of the Workers' Compensation Board to the government entity listed above.

SIGN HERE	Signature 	Date:
Exemption Certificate Number 2015-		Received  NYS Workers' Compensation Board